Prevention and screening – the role of continuing medical education and the professional development of general practitioners

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This article will explore the role of education in encouraging clinicians to engage with their patients on the topic of prevention and screening. It will start with a description of the process by which clinicians learn. There will then be an exploration of the conditions that are required for a change in the behavior of clinicians. Finally there will be a discussion of how to design educational interventions that will support change and look at how to apply this to the field of prevention.
Key words: *prevention, screening, family practice, education.*

Continuing Medical Education has been defined by the American Medical Association as: *'Any and all ways by which physicians learn and change'.*

The UK General Medical Council defines professional development as:

A continuing process that enables individual doctors to maintain and improve standards of medical practice through the development of knowledge, skills, attitudes and behaviour.

There has been a significant amount of work done in the last century about how adults learn. This work has been used to help us understand how professionals develop. When many senior doctors attended medical school the emphasis was on learning facts. It is now clear that real learning is not just about facts. Bloom's classification of learning [1] acknowledges the importance of knowledge or facts but also describes the importance of understanding the significance of those facts and of being able to apply them in order to solve real-life problems. This requires the analysis of information, and using it to determine the best course of action. This process enables the knowledge to be combined with experience to produce what has been described as 'practical wisdom'.

Many of the problems clinicians encounter are complex and not solved by referring to a guideline or textbook. There is evidence that conversations with respected peers enable clinicians to reflect on their practice, clarify confusions, correct misunderstandings and make sense of their experiences [2].

Clinicians commonly use medical meetings to learn about new approaches to practice and to acquire new skills. As medical educators we need to be able to offer medical meetings that support this kind of learning. The latest Cochrane review looking at the effectiveness of medical meetings has found evidence that a combination of lectures and interactive sessions works best [3]. This combination encourages conversations about how to apply the material presented and to practice new skills.

There is good evidence for the usefulness of small group work in helping clinicians to change their practice [2]. Small group work enables social interaction between members, which stimulates learning, raises individuals' confidence and increases motivation. To be effective small groups require careful leadership – this creates a safe environment and fosters mutual respect amongst members.

It is important to be aware of the circumstances that interfere with our learning. A study identified the following factors that interfere with learning: Lack of peer contact as occurs when we experience geographical isolation, heavy workload, competition with colleagues for funding to attend courses, lack of time for study [4]. In addition, there are factors related to the doctor, such as being disillusioned or depressed.

The topic that this article is considering is prevention and screening. We need to be clear about our curriculum or what we are trying to teach. This could be considered as the Basics of Prevention and I will illustrate it with an example – the prevention of familial colonic cancer. We need to understand the patterns of disease e.g. genetically determined increased incidence of bowel cancer, then to assess risk factors e.g. strong FH bowel cancer. There must be the appropriate selection and use of screening tests e.g. the use of genetic testing and regular colonoscopy for selected groups. Patients need to be motivated to change their behaviour; they need to understand why the referral has been made and be encouraged to attend for screening and we need to attend to the importance of preventing overdiagnosis and over treatment e.g. by only referring true at risk groups. Finally the intervention needs to be affordable for a health care system and in particular there needs to be money to pay for the management of the people who test positive.

It has been recognised for many years and now reinforced by the World Health Organisation, that family medicine is the ideal setting for prevention as we have frequent encounters with the population, we build up trusting relationships over time, and we have the responsibility for preventive programmes such as immunisation [5]. There is also the evidence that brief lifestyle interventions from a trusted physician can be effective.

Our patients would like us to discuss their issues around lifestyle with them. A EUROPREV study identified that >50% recognise the need to change aspects of their lifestyle and that two thirds would like their GP to discuss lifestyle change with them [6].

However 56 % of European General Practitioners [GPs] admit to finding this difficult and the following barriers have been identified: Heavy workload, lack of time, no reimbursement, doubts about effectiveness and also our personal behaviours such that GPs who smoked find it harder to raise the issue with patients than GPs who do not smoke [7]. The same study identifies factors that made it easier to engage with patients about their lifestyle: the GPs were unanimous in their opinion that working with a practice nurse was helpful, as were the availability of local programmes. Personal behaviour was also seen as a facilitator; the study found that GPs who took regular exercise found it easier to discuss exercise with their patients.

There is good evidence found from repeated Cochrane reviews that simple smoking cessation advice from GPs can help up to 3% of patients stop smoking and that more intensive input increases

quit rates [8]. Now 3% may not sound like a large number, but given the risks of smoking over time this will be significant.

We need to identify those times when patients present with particular health problems that mean they will be receptive to change. The smoker who presents with intermittent claudication will gain significant benefit from stopping smoking [9]. Cardiovascular disease risk assessment tables can give clear information on the benefits of stopping smoking [10].

A further Cochrane review has made it clear that interventions designed to deal with identified barriers are more likely to improve professional practice and that the dissemination of guidelines or educational materials are not likely to make change on their own [11].

So – how can we encourage GPs to participate in preventive work with their patients?

Training, from what we have heard, needs to involve Information giving, discussion with peers and the acquisition of skills. We must not underestimate the importance of organisational support that recognises the importance of this work and that offers referral options for patients. Helping patients to improve their lifestyles has long been recognised as the best way improve their life expectancy and quality of life:

"If we could give every individual the right amount of nourishment and exercise, we would have found the safest way to health". Hippocrates (460-370BC)

Профілактика та скринінг – роль безперервної медичної освіти і професійного розвитку сімейних лікарів (Доповідь на конференції «Здоров'я українців – в руках сімейних лікарів», 8–9 грудня 2016 року, м. Київ)

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У статті розглянуто роль освітнього процесу у заохоченні лікарів до проведення превентивних і скринінгових програм для пацієнтів. Описано процес навчання клініцистів та умов, необхідних для впровадження змін у діяльність практикуючих лікарів. Також обговорюються методи навчання, які підтримують позитивні зміни та їхнє впровадження у галузі профілактики.

Ключові слова: *профілактика, скринінг, загальнолікарська практика, освіта.*

Профилактика и скрининг – роль беспрерывного медицинского образования и профессионального развития семейных врачей (Доклад на конференции «Здоровье украинцев – в руках семейных врачей», 8–9 декабря 2016 года, г. Киев)

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В статье обсуждается роль обучения в мотивации клиницистов для проведения профилактических и скрининговых программ для пациентов. Описан процесс обучения врачей и условия, необходимые для внедрения изменений в деятельность практикующих специалистов. Также обсуждаются методы обучения, которые поддерживают позитивные перемены и их внедрение в области профилактики.

Ключевые слова: *профилактика, скрининг, общеврачебная практика, образование.*

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